# ESTIMATES OF COUNTY SAVINGS IF MEDICAID ELIGIBILITY IS EXPANDED AS ALLOWED BY THE AFFORDABLE CARE ACT

February 14, 2013

The Department of Human Services (Department) used state fiscal year 2012 (SFY12) county service data to estimate savings counties may experience if Medicaid eligibility is expanded for all individuals up to 138%[1] of the federal poverty level (Medicaid Expansion Group) as allowed by the Affordable Care Act. Based on the following potential benefit plans for the Medicaid Expansion Group the estimated ranges of annual savings are:

- State's Largest HMO $27M to $29M
- State Medicaid Plan $55M to $60M

Counties pay for services not reimbursed by Medicaid using county levy funds and $12.5M state funds provided through the state payment program. Services not reimbursed by Medicaid are for:

- Persons who are not Medicaid eligible
- Services that Medicaid does not cover

County Service Data:

- Counties report their service costs for the previous state fiscal year each December
- The Department used the most recently reported data for SFY12 in making this estimate
- County service cost data combines Medicaid and non-Medicaid costs as well as enterprise costs for services the county provides directly
- Enterprise costs were identified and removed, but it is difficult to separate non-Medicaid from Medicaid costs

Medicaid Expansion Benefit:

- States have flexibility regarding what benefit plan to use for the Medicaid Expansion Group
- In calculating savings the Department assumed that the Centers for Medicare and Medicaid Services (CMS) will require the expansion benefit plan to include behavioral health parity
- The plans used in the estimate are:
    - The largest HMO plan in Iowa – Blue Advantage
    - The Medicaid State Plan

Estimates of County Savings:

- The Department compared the counties' reported cost by chart of account codes with the benefits covered by the two plans
- The Department identified potential savings for services where the county chart of accounts matched the benefits listed in the plan

[1] The Medicaid Expansion Group threshold is 133% FPL, but 5% of an individual's income is disregarded, effectively raising the limit to 138% FPL.

Assumptions - The following assumptions were used in making these estimates:

- Case management services would be covered by Medicaid, but not the HMO plan. Counties currently expend significant amounts for case management for persons who are not Medicaid eligible.
- Habilitation services for persons with a chronic mental illness would be covered by Medicaid, but not the HMO plan. County service data:
    - The residential care facility (RCF) account codes combine the costs of providing services and supports to the individual with room and board costs
    - Payments made to large and small RCFs are also combined in the account codes
    - Only services costs provided in small (16 beds or less) RCFs can be paid by Medicaid
    - The Department assumed that, at most, $5M of about $20M in RCF costs for persons with mental illness would qualify for Medicaid reimbursement
- Non-Medicaid costs associated with Home and Community Based Services (HCBS) Waiver Services were not included. The Medicaid Expansion Group does not include individuals that would otherwise be eligible for HCBS waiver services.
- Costs of services not included in the estimate include:
    - Room and Board
    - Subsistence
    - Sheltered workshops
    - Large residential settings for persons with mental illness
    - Cost of services for other population groups such as individuals who have a developmental disability that is not an intellectual disability and children.
- The final identified amount was discounted 10% to account for the difference between the 138% FPL eligibility limit for the Medicaid Expansion Group and the 150% FPL eligibility used by most counties